Northern Lakes
COMMUNITY MENTAL HEALTH AUTHORITY

Medication Pass Observation Sheet

Employee Name:_____ Date Attended Medications Training:_____

Provider Name: _____ Supervisor Name:_____

Email Address: _____ Phone Number: _____

Client Initials/Home Name	Date and Time of Medication Pass	Staff who Shadowed/Observed

It is home manager's discretion if the completion of a minimum of 7 shadowed/observed medication passes is an adequate amount of training. A final return demonstration will be completed with the home manager to determine if the employee is able to pass medication independently. Should an error occur at any time—it should be reported to your designated nurse consultant who will determine if a remedial training is necessary.

Attach completed and signed medication demonstration sheet; scan and email both forms to training@nlcmh.org or fax to 231-876-0353 and save both forms on site for your records.

Date of return demonstration: _____

Manager Name: _____ Manager Signature:_____